Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-2678-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: A position summary was not submitted.

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $991.52

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "[Injured worker] submitted a request for medical dispute resolution on February 1, 2010 for prescription medication that he paid for himself on August 28, September 25, October 23, November 19, and December 15, 2009 and is seeking reimbursement in the amount of $991.52. Based upon the information submitted by [injured worker], it is impossible to determine the type of medications for which he paid. The carrier has some medical records discussing different types of medication, but one cannot tell from the documentation submitted by [injured worker] the type of medication for which he paid. As such, [injured worker] is not entitled to reimbursement. In addition, the carrier obtained a peer review report on August 28, 2009 by John Martell, Jr., M.D. who performed a comprehensive review of [injured workers] records. Dr. Martell concluded that according to the diagnosis suffered by [injured worker] and the Official Disability Guidelines, no further treatment is medically reasonable or necessary. This peer review was sent to Dr. Fino and to [injured worker's] last known address."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
08/28/2009 – 12/15/2009	No EOBs submitted	Out-of-Pocket expenses – Prescription Medication	$991.52	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. In accordance with Texas Admin Code Section §133.307(c)(3) and employee who has paid for health care may request medical fee dispute resolution of a reimbursement request that has been denied. The employee's dispute request shall be sent to the MDR Section by mail service, personal deliver or facsimile and shall include: (A) the form DWC-60 table listing the specific disputed health care in the form and manner prescribed by the Division; (B) an explanation of the disputed amount that includes a description of the health care, why the disputed amount should be reimbursed and how the submitted documentation supports the explanation for each disputed amount; (C) Poof of employee payment (including copies of receipts, provider billing statements, or similar documents); and (D) a copy of the carrier's denial of reimbursement relevant to the dispute, or if no denial was received convincing evidence of the employee's attempt to obtain reimbursement from the carrier. The information submitted to Medical Fee Dispute Resolution does not list the names of the prescription drugs the injured worker paid for nor did the injured worker submit convincing evidence that a request for reimbursement was made in accordance with 28 Texas Admin Code Section §133.270.

2. According to the Respondents position summary the carrier obtained a peer review which concluded that no further treatment was medically reasonable or necessary. According to 28 Texas Admin Code Section §133.305 Medical Fee Dispute Resolution does not have the authority to review issues of medical necessity.

3. Therefore, for the reasons noted above, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		July 6, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.